Ninety-Ninth Legislature - First Session - 2005
Committee Statement
LB 389

Hearing Date: February 8, 2005
Committee On: Banking, Commerce and Insurance

Introducer(s): (Mines, Redfield)
Title: Adopt the Health Care Prompt Payment Act

Roll Call Vote – Final Committee Action:

	Advanced to General File
X	Advanced to General File with Amendments
	Indefinitely Postponed

Vote Results:

8	Yes	Senators Mines, Redfield, Flood, Jensen, Johnson, Langemeier, Louden, Pahls
	No	
	Present, not voting	
	Absent	

Proponents:	**Representing:**
Senator Mick Mines	Introducer
David Filipi	NE Medical Association
Keith Shuey	South East NE Rural Physicians Alliance
Roger Keetle	NE Hospital Association
Michael Kasher	NE Medical Group Management Association
James Cavanaugh	Creighton University Medical Center
Bill Peters	Golden Rule Insurance Company
Dave McBride	NE Association of Insurance and Financial Advisors
Opponents:	**Representing:**
Neutral:	**Representing:**

Summary of purpose and/or changes:

LB 389 (Mines) would enact nine new sections to be known as the Health Care Prompt Payment Act.

The bill would provide, section by section, as follows:

Section 1 would provide for a named act: the Health Care Prompt Payment Act.

Section 2 would provide definitions for terms: “clean claim” (a claim for payment of health care services submitted to an insurer on the insurer’s standard printed or electronic transaction form with all required fields completed); “director”; “insurer”; “prompt payment act compliance statement” (a certification made in good faith by an insurer that, during the twenty-four-month period ending on the preceding June 30, it paid, denied, or settled more than ninety percent of its clean claims within the time periods set forth in section 4 of the bill); “repricer” (an entity that receives claims from health care providers and submits them to insurers after adjudicating or repricing such claims”; and “unfair payment pattern” (an unjust pattern of reviewing or processing complete and accurate claims that results in payment delays; an unjust pattern of reducing the amount of payment or denying complete and accurate claims; repeated failing to pay the uncontested portion of a claim within the time periods specified in section 4 of the bill; and repeated failure to pay the interest when due on claims pursuant to section 5 of the bill).

Section 3 would provide for presumptions regarding receipt of claims submitted electronically and submitted by mail.

Section 4 would provide that a clean claim shall be paid, denied, or settled within thirty calendar days after receipt by an insurer if submitted electronically and within forty-five days of receipt if submitted in another form.

This section would further provide that if the resolution of a claim requires additional information, the insurer shall, within thirty calendar days after receipt, give the provider, policyholder, insured, or patient, as appropriate, a written explanation of what additional information is needed; that the person receiving a request for such additional information shall submit all additional information requested within thirty days after receipt of such request; that after such additional information is provided, the claim shall be paid, denied, or settled within the remaining applicable thirty or forty-five day time period; and that the insurer may deny a claim if a provider fails to submit additional information requested under this subsection.

Section 5 would provide that an insurer that fails to pay, deny, or settle a clean claim in accordance with or take other required action within the time periods set forth in section 4 of the bill shall pay interest at the rate of twelve percent per annum on the total amount ultimately allowed on a claim from the date payment was due pursuant to section 4 of the bill.

Section 6 would provide that an insurer shall be exempt from the interest requirements of section 5 of the bill during a calendar year when the insurer has a prompt pay act compliance statement on file with the Director of Insurance.

Section 7 would provide that if an insurer delegates its claims processing to a third party, the third party shall consent to examination by the Director of Insurance and shall comply with the act.

Section 8 would provide that the Director of Insurance shall compile a record of notices from insureds, representatives of insureds, and health care providers acting on behalf of insureds related to unfair payment patterns and if the director investigates and finds, after hearing, that an insurer or third party working on behalf of the insurer has engaged in an unfair payment pattern or that the insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, the director shall issue a cease and desist order and may order (a) payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate of thirty thousand dollars, unless the violation was flagrant and in conscious disregard of the act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate of one hundred fifty thousand dollars, (b) suspension or revocation of the insurer's license or certificate of authority if the insurer knew or reasonably should have known it was in violation of the act, and (c) withdrawal of the insurer's prompt payment act compliance statement. An insurer that violates a cease and desist order would be subject to a monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate of one hundred fifty thousand dollars and suspension or revocation of the insurer's license or certificate of authority.

Section 9 would provide that the act does not apply to a claim submitted before January 1, 2006.

Section 10 would provide the Director of Insurance with rule and regulation authority to carry out the act.

Explanation of amendments, if any:

The committee amendments (AM0572) would:

(1) amend section 2 by re-writing the definition of "clean claim" and inserting a definition for a new term, "claim form", in order to clarify that if an insurer does not have a standard printed or electronic transaction form, then a provider shall submit a claim on a form that complies with standards issued by the Secretary of the United States Department of Health and Human Services.

(2) amend section 4 to provide that:

(a) the applicable time period within which a clean claim shall be paid, denied, or settled (thirty days for claims submitted electronically and forty-five days for claims not submitted electronically) shall be tolled from the date additional information to resolve the claim is requested by the insurer until the date the additional information is received by the insurer, and

(b) a clean claim does not include a claim for which the insurer needs additional information to resolve issues concerning "coverage" or "eligibility" as well as issues concerning coordination of benefits, investigation of preexisting conditions, subrogation, determination of medical necessity, or the use of unlisted procedural codes.

(3) amend section 9 to provide that the act does not apply to policies that provide coverage for "a specific disease," "accident-only coverage," or "other limited-benefit coverage"

as well as hospital indemnity coverage, disability income coverage, Medicare supplement coverage, and long-term care coverage.

Senator Mick Mines, Chairperson